SUICIDE

SUICIDE IN CHANGING SOCIETIES

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To the untrained eye, suicide may appear to be a highly individual decision, and undoubtedly it is. However, it can be shown that suicide, as with the results of so many other individual choices, is also a socially patterned and socially reactive phenomenon. This essay attempts to say something about its relationship to changes in the surrounding society.

Since ancient times, suicide has been an object of moral and philosophical speculation; later, it also became a matter for medical and social-scientific thought. However, it became a focus of major attention only when, during the 19th century, the newly initiated mortality statistics revealed a relentless increase in the suicide rate.[1] The Swedish rate of suicide, for example, increased fivefold between 1810 and 1912.[2] Scholars from many scientific disciplines – medical, social, behavioral, legal, theological – competed in offering explanations for this startling phenomenon. It was generally suspected that the drastic social changes associated with the processes of industrialization and urbanization were somehow related to the rising suicide rate – but how exactly?

The theory that won the day (or at least the posterity) was developed by the French sociologist Émile Durkheim in his famous book *Le Suicide*, which first appeared in 1897.[3] The book can be (and has been) criticized as regards both data quality and the methods used for empirical testing, especially when judged by modern standards. In addition, its theoretical contents, while fascinating, are not always stated very clearly, which sometimes allows the author to use them in an ad-hoc manner in explanations.[4] Nevertheless, as a study of suicide as a societal phenomenon, the impact of *Le Suicide* has been of major importance: it is still the leading theory and a natural starting point for any study.

DURKHEIM ON SOCIETAL CHANGE AND SUICIDE

Durkheim presented a systematic theory of suicide mortality. It consisted of several elements, one of them being the claim that the level of suicide in a society correlates with the level of societal *regulation*, i.e. the regulation, on the part of society, of individual goals and aspirations. This regulation originates in social morality, as shared by and superior to the individual members of society. It sets limits on the individual's aspirations and desires and prescribes appropriate and attainable goals for individuals in different social positions and with varying resources and opportunities.

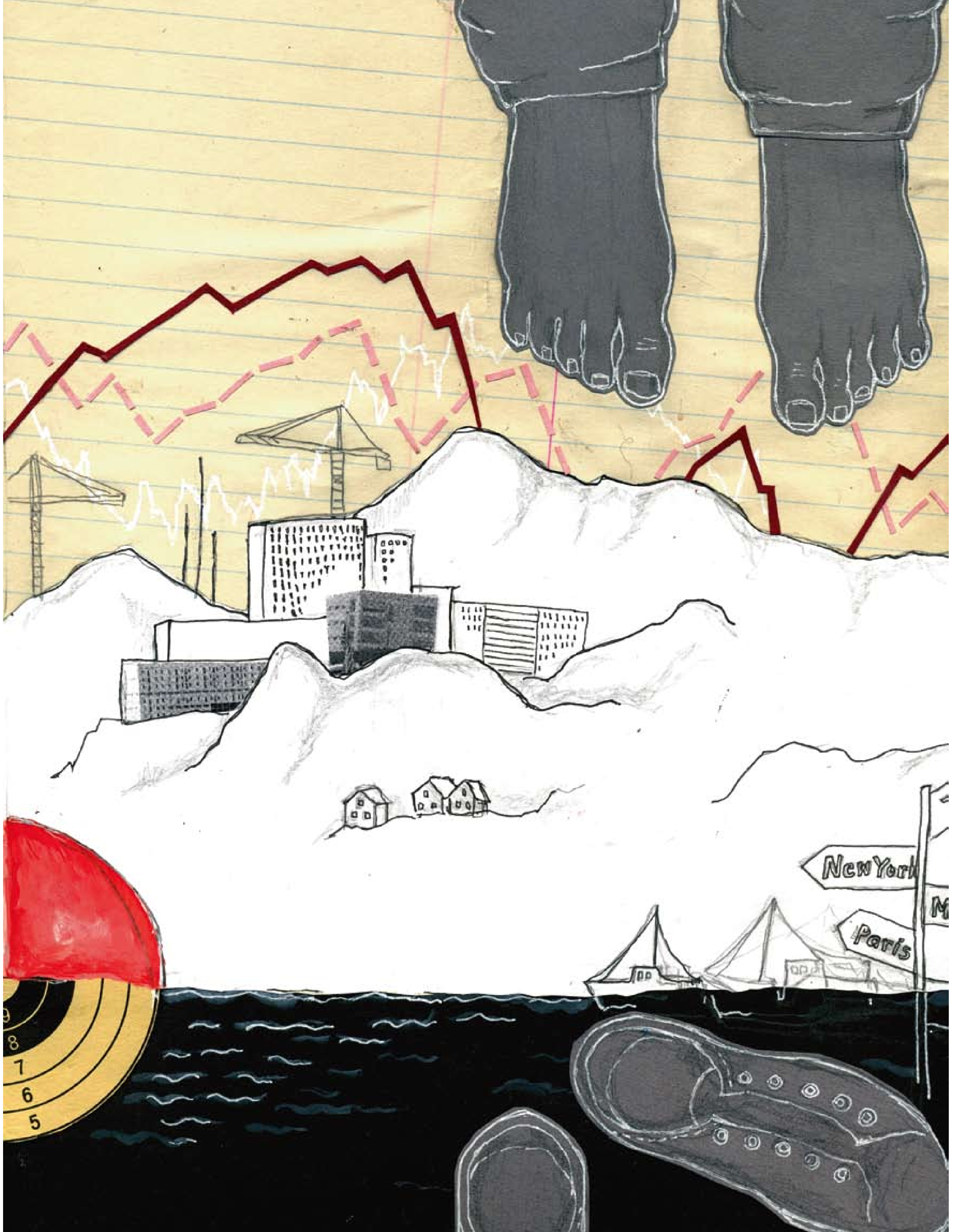
In Durkheim's opinion, human needs, in contrast to those of animals, exceed the purely physical ones, and their number or form cannot be absolutely determined. As a consequence, the satisfaction of the needs is always an uncertain and arbitrary matter. Thus, if they were dependent only on individual aspirations, the individuals' desires and goals would always be unattainable, and the individual would be left in a perpetual state of disappointment and dissatisfaction. However, in a normally functioning "Durkheimian" society, this state of affairs is avoided by means of societal regulation of both the desirable goals and the means of attaining them. This encourages the individual to reach a realistic contentment with his or her lot, a fate that he/she can try to improve by working in conformity with the regulation. As a result, the individual will "be able to love what he has and not solely fixate on what he lacks".[5]

But when a society is in crisis, or affected by some abrupt change, it will sometimes become incapable of exercising its regulative influence on individual needs. When conditions of life change, the standards according to which needs are regulated cannot remain the same. Nor can a new standard be immediately implemented. Thus, for a time, the limits of what is possible, just, and legitimate in relation to individual needs will be unknown. This will result in a state of uncertainty in which individual needs, passions, and aspirations are unlimited and uncontrolled, a state of society known by its Greek-inspired name *anomie*. At the societal level, it is characterized by deficient regulation, at the individual level, by constant disappointments caused by unattainable goals and unmet aspirations. According to Durkheim, a society in a state of anomie will experience a great increase, for that location and time, of a specific type of suicide which he terms *anomic*. Some of Durkheim's statements seem to indicate that he believed that society in a process of modernization as such had an unbalanced, anomic character, and that similar reasoning could, perhaps, be applied to other rapidly changing societies too.

THE ECONOMY AS LOCUS OF DISORDERLY CHANGE

In Durkheim's opinion, the economic sector was the most visible social sphere in which anomic imbalances

A world of opportunities offers a great many shortcomings. Even the Greeks had words for this.



Anxiety is the iceberg of change. At the top, people fall with different weights.

could be found, and the boom-and-bust capitalism of the late 19th century provided him with a wealth of examples of rapid changes in fortune. Interested as he was in a possible correlation between economic changes and levels of suicide mortality, he was able to show how disruptions or changes in the economy, be they upswings, recessions or reforms, were *all* associated with increases in suicide mortality levels. This type of reaction could, in his opinion, only be explained by assuming that it was the change per se, and not the particular nature of the change, that affected the level of suicide mortality. The disequilibrium brought on by rapid societal change caused people to commit suicide more frequently.

Durkheim did not see the origins of anomie as solely economic. Change in the family structure was another potential source of anomie, as the higher suicide rates among divorced men, in his opinion, indicated. Divorce brought about a state of disequilibrium, because it interrupted the regulative functions of marriage, the regulation of "the life of passions"[6], i.e. sexual relations. It did not have this effect on women for their desires were "naturally limited" due to their "less developed" mental life[7] (a line of reasoning consistent with Durkheim's general ideas about the mental life of women).

Yet divorces were not numerous in Durkheim's time, whereas there was an abundance of economic change. Table 1, which is taken from *Le Suicide*, contains an everyday example of how suicide levels increase during events, such as the World Exposition, that supposedly stimulate business activity and increase public wealth in the city where they occur. Guided by Durkheim, the reader will observe the increase in suicides in Paris in 1889, the year of the World Exposition. During the seven months the Exposition lasted, suicides increased by almost 10 percent in comparison to the previous year (567 suicides compared to 517), while, the following year, the number of suicides was again lower for the same months.[8] Durkheim goes on to give further examples of the relationship between suicide rates and economic change by showing how suicide rates increased during financial crises and stock market crashes and how they correlated with increases in bankruptcies and variations in food prices, production, trade, and public wealth.

Durkheim's fundamental idea, that change in itself could be destructive, has been an inspiration for those coming after him. As far as individual examples are concerned, empirical tests have often given differing results. Durkheim's original assumption that any change in the economy would lead to an increase in suicide mortality was confirmed in the 1970s by Albert Pierce.[9] Using fluctuations of stock-market prices as indicators of economic change, he found a strong positive correlation between (white male) suicide rates and the absolute rate of change in the economic cycle, regardless of its direction. Pierce's findings were later questioned by James R. Marshall and Robert W. Hodge[10], who criticized certain aspects of his method and argued, with support from their own findings, that it was not a matter of economic disruption per se. Instead, they found that suicide increased during negative changes in the economy and decreased during improvements, contrary to what Durkheim had postulated.

Table 1. Suicide Mortality in Paris Before, During, and After the World Exposition of 1889

	1888	1889	1890
The seven months of the exposition	517	567	540
The five other months	319	311	356

Source: Émile Durkheim, Suicide: A Study in Sociology, London, 1999, p. 245.

Maurice Halbwachs, one of Durkheim's adepts, had earlier advanced a similar argument. According to him, suicide increased during economic crises, not necessarily as a direct consequence of unemployment, bankruptcies, failures, and downfalls, but because of less general activity and people's decreased participation in economic life. This created a situation where people's "attention is no longer turned towards externals but dwells more, not merely on their distress or on their bare material competency, but on all the individual motives they may have for desiring death".[11] Halbwachs' argument reminds us of Durkheim's other main theme, namely the association between suicide levels and the level of societal *integration*.

This second aspect of Durkheim's theory predicts that the risk of suicide will increase among lonely and self-centered individuals, and that loneliness and self-centeredness may be promoted by prevailing social circumstances. In fact, for Halbwachs,[12] the aspects of societal integration and regulation were both a result of a common denominator: the individual's attachment to society. Others after him[13] have agreed that the two – integration and regulation – are simply aspects of the same societal condition.

A MODERN EXAMPLE: THE TRANSITION IN EASTERN EUROPE AND THE CHANGES IN SUICIDE MORTALITY

Durkheim's theory of a link between rapid social change and suicide mortality may seem very plausible when applied to 19th century Europe, where rapid social change and increasing suicide rates were virtually ubiquitous.[14] However, one set of examples is hardly sufficient as evidence for answering the general question.

In our times, the fall of Communism has brought major changes in East European societies over the last two decades. The ensuing transition has influenced all levels and all spheres of society, not least the economic and the political; it has had a major effect on the lives of some 400 million individuals. For many, the change has meant increased poverty, social inequality, unemployment, and uncertainty about the future, while for others it has meant increasing personal, political, and economic freedom. In accordance with the above-mentioned theories, one might expect Eastern Europe's transition to affect suicide mortality in two distinct ways. First, on lines with Durkheim's theory, change per se causes anomie, which, in turn, should affect the levels of suicide mortality. Second, suicide mortality should be affected by the negative character of the economic changes in many of these countries, accompanied, as they have been, by reduced purchasing power and increased unemployment.

The negative consequences undoubtedly exist. The state of public health in Eastern Europe started to stagnate as early as the mid-1960s. The rapid transformations of the early 1990s caused a severe deterioration of an already precarious situation. The former Soviet republics experienced dramatic increases in their mortality rates, especially among men, and suicide mortality was no exception. Rather, the increases in suicide levels in some of the East European countries were of such magnitude that it is scarcely possible to find their counterparts in 20th century history. In Russia, suicide mortality increased by 62 percent between 1989 and 1994, in Lithuania (which presently has the highest suicide mortality rate in the world), the increase during this same period amounted to 69 percent (see Figure).[15]

These alarming developments soon caught the attention of researchers.[16] In terms of theories about suicide, they pose serious problems for those who claim that suicide is always a result either of serious psychiatric illness or of specific genetic makeup.

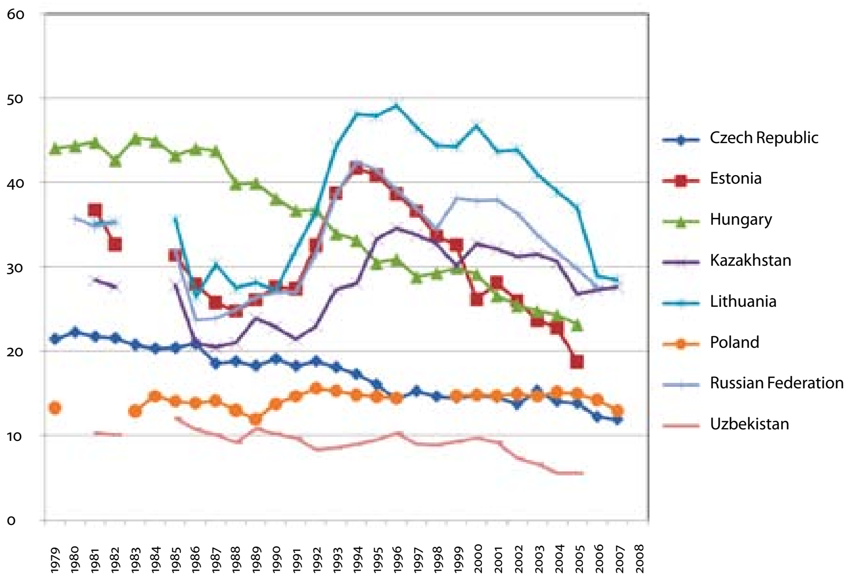
When a systematic comparison is done of developments of suicide mortality after 1990 in the transition countries, one may find patterns that indicate significant differences between groups of countries. The Figure presents the course of events in selected East European countries which may be considered representative. For example, the developments in suicide mortality after 1990 in the former "European" Soviet countries (except for Moldova), i.e. Russia, Ukraine, Belarus and the three Baltic States, are fairly similar.[17] All of these countries saw sharp rises in suicide mortality in the years after 1990; moreover, suicide levels were already very high in all of these countries. In the middle of the 1990s, the rates peaked. Thereafter, a general decrease in suicide rates has occurred, except for Russia where the ruble crisis of 1998 seems to have been followed by yet another increase in suicide mortality from 1999 to 2001.

Poland, Romania, and Kyrgyzstan are additional examples of countries where increases in suicide mortality can be observed in the beginning of the transition period. These increases were, however, less dramatic than in the countries discussed above. In the rest of Eastern Europe, i.e. Hungary, the Czech Republic, and the Balkans, suicide mortality rates remained fairly stable, or even decreased. This was also the case in the Caucasian and Central Asian former Soviet republics. In other words, a "suicide crisis" occurred in only eight of the 28 East European countries, and even though it was of unprecedented severity, we must ask why this did not happen in all of the countries concerned. After all, the pains of the transition period were most certainly more severe in Albania than in Estonia, and surely no less serious in Romania than in Latvia. These cases, which actually constitute the majority of the countries involved, are not easily reconciled with Durkheim's theory, according to which the changes that were common to all these countries – and that ought to have interrupted societal regulation – should have resulted in increasing suicide rates in all of them.

Where suicide rates did increase, it is possible that

The Eiffel Tower was built for the 1889 World Exposition. The number who jumped?

Figure. Suicide and Self-Inflicted Injury in Selected East European Countries, 1979–2008



Source: World Health Organization: Health for All Data Base

the societal changes following the transition also involved other factors that made the members of these societies more prone to commit suicide. For example, Lisa F. Berkman and her colleagues claim that large-scale societal changes, such as the East European transition, "represent environmental challenges that tear at the fabric of social networks".[18] Such deterioration in social relations in post-Soviet societies could be related to the second of Durkheim's claims, namely that suicide levels vary with the degree of integration of society.

This picture is further complicated by a wide range of more specific explanations supplied by scholars studying the observed increases in suicide mortality in Eastern Europe. The increased suicide levels have been associated with factors such as the deteriorated macro-economic conditions[19], increased alcohol consumption[20], increased divorce rates[21], and the general fragmenting of social relations[22].Suicide levels have also been explained by referring to a generally increased level of stress and social disorganization[23], as well as the deterioration of medical care[24]. Other authors have, in accordance with Durkheim's general theory, emphasized the impact of rapid *change* per se[25] while still others have stressed the sole importance of rapid *economic* change, independent of the level of prosperity[26]. In addition, a negative association between the process of democratization and suicide mortality has been reported, implying that democratization has some beneficial effects on suicide mortality levels.[27]

However, these factors seem to be able to explain only parts of the variation in suicide mortality in the respective countries, and they do not predict well at all in many of them. The explanations offered for the rise in suicide rates seem merely to reflect the general variation in the opinions of suicide's societal causes. The process of societal change in Eastern Europe has been so thoroughgoing that it can give rise to many possible interpretations; it is hard to separate individual elements of the intertwined processes. This analytical situation is known as multicollinearity – when everything happens at once, the exact causes of the phenomena are difficult to specify.[28] Moreover, as can often be observed in social-scientific research, the focus has been on the problematic changes. Meanwhile, the positive changes have gone largely unnoticed, although they, too, might deserve an explanation. Since 2000, the level of suicide mortality has been decreasing in most of the countries concerned.

SOME POINTS OF COMPARISON: CHANGES IN THE THIRD AND FOURTH WORLDS

For the sake of comparison, let us take a brief glance at another rapidly changing society – that of China. Since 1980, the country has risen from a poor, barely industrialized and barely self-supporting society to a major economic power and a world-class exporter of industrial goods, a development which, in its rapidity and comprehension, is certainly comparable to what took place in 19th century Europe.

It is difficult to estimate the level of suicide mortality in China, since the country has no national death registration system. The tabulation of deaths by cause is based on population samples. The national suicide mortality rate has been estimated at 15.4 per 100,000 in 2000[29], a figure not much higher than that of Sweden (11.4 per 100,000 in 2007[30]). Suicide mortality in China seems to have some unique characteristics. China is the one country where female suicide mortality levels exceed those of males. Moreover, suicide mortality levels are estimated to be about three times higher in the countryside than in the cities.[31] Whereas these characteristics of Chinese suicide mortality differ from those in the West, (other) risk factors that have been associated with suicide mortality in China, such as depression, previous suicide attempts, and acute stress at the time of death, seem to mirror what has been observed in the West.[32]

The high suicide mortality among rural women has been the focus of many studies, and has been linked to these women's low status and limited options; they may, for instance, be subjected to forced marriages, abusive husbands or in-laws, stress caused by official birth policies, pressure from parents that want them to help the family escape rural life, etc.[33] However, as noted by Michael R. Phillips and his colleagues, women in many developing countries face a similar situation. In their own study, they find support for the hypothesis that it is the lack of religious or legal prohibitions against suicide in China that may make suicide an acceptable way of escaping a difficult situation, a circumstance that bears no intrinsic relation to China's modernizing development.[34]

The link between China's suicide mortality levels and economic development is difficult to determine due to absence of past statistics.[35] The estimations for the levels of suicide mortality during the 1990s seem to indicate that suicide mortality has either remained relatively stable[36] or has even fallen[37], depending on how the calculations are carried out. In seeking to explain the possible decline in suicide mortality, it has been hypothesized that while positive relationships between modernization and suicide have been found in other societies, in largely rural environments, such as the Chinese, modernization might cause *decreases* in suicide mortality because of the attendant general improvements in living standards, better educational opportunities, and better medical care.[38] Moreover, the decrease in suicides in rural areas seems driven by a decrease in young women's suicide rates.[39]

These facts would again raise questions about Durkheim's theory. The Chinese experience of changing suicide rates during periods of rapid social change,

China – the contrary society. The rule-less exception!

seems to have been very different from that observed in Western or Eastern Europe. It further stresses the importance of the initial social and cultural situation, as well as the direction of the change.

Probably the most extreme social changes in the world are those experienced by "fourth world" peoples – traditionally small-scale, hunter-and-gatherer societies with limited contacts with the outer world. Globalization has often entailed either dramatic changes in or the disappearance of these societies. A Nordic example is that of Greenland.

For the last 50 years, Greenland's development from a traditional society to one approaching a modern (Western) style of life has been marked by rapid socio-cultural transformations. These have gone hand-in-hand with large increases in suicide mortality, especially among young men. While Greenland had two registered suicides in 1971 (4.2 per 100,000) the level increased sharply, reaching its peak with 69 cases in 1987 (128.4 per 100 000), a thirty-fold (!) increase in only 16 years. And while suicide mortality decreased after a second peak in 1990 (118.8 per 100,000), it has fluctuated at a continuously high level (77.3-105.4 per 100,000) between 1991 and 2002.[40] Markus Leineweber and his colleagues observed differences in the trends in suicide mortalityfrom one region to another, and they hypothesized that these were related to the variations in the influence of Western culture between the regions. Western influence began at different points of time in different areas, and the first peaks in suicide mortality increases seemed to occur in the regions that were first exposed. The initial period of influence would be marked by pronounced social and cultural changes, and suicides would increase. A subsequent period of adaptation to the new situation would be accompanied by the stabilization or decrease in suicide mortality levels. Furthermore, a lack of stable social networks seemed to be associated with suicide mortality at the individual level in Greenland.[41]

WHY DON'T ALL CHANGING SOCIETIES EXPERIENCE RISES IN SUICIDE MORTALITY?

Returning to Eastern Europe, it is important to re-emphasize the fact that the developments in suicide mortality in the beginning of the 1990s varied greatly from country to country. Although all of them experienced similar societal transformations, the effect of these in relation to suicide mortality has not been identical, or even similar. Not even all the former Soviet countries, which, after all, share a longer common history, experienced similar developments in this respect. This seriously calls into question the general Durkheimian theory, according to which transformations per se, and the anomie that they cause, should lead to higher levels of suicide mortality. This is clearly not the case in the East European experience, and it is unlikely that other Durkheimian factors such as, for example, decreasing societal integration, could save the theory here.

A possible explanation for the variation in the effects of the societal transition on suicide mortality could be that the effect of social factors on suicide mortality is dependent on the context and, in particular, the *culture* of the specific environments undergoing societal transition. In a study on the development of suicide mortality in East Europe before and after the transition, one of the authors[42] found that Eastern European countries could be divided into groups according to the specific properties of their suicide mortality, that is, their different "suicide mortality profiles". These profiles were based on the level of suicide mortality and the distribution of suicide among sex and age groups (see Table 2), which were, in turn, thought to reflect different socio-cultural situations in relation to suicide. Countries with similar profiles also tended to follow similar developments in their suicide mortality during the relevant time period. The suicide mortality profiles seemed to be *mediating* the effects of (other) social factors that were used to explain the variations in suicide mortality, causing the effects to vary greatly. The profile groups remained almost the same during the two periods that were studied (1984-1989 and 1989-1994), which means that the profile differences were not altered by the transition process. Subsequent (still unpublished) research further supports the premise of their basic stability.

Thus, the general culture in these countries seemed to have a more significant determining effect on suicide than did (other) social factors. In his book, Durkheim gave only very fleeting consideration to cultural influences[43], when mentioning the Greeks. It seems, however, that a mental link of some generality needs to be added to the societal circumstances and the suicidal reactions before the theory can hope to explain change in society and suicide.

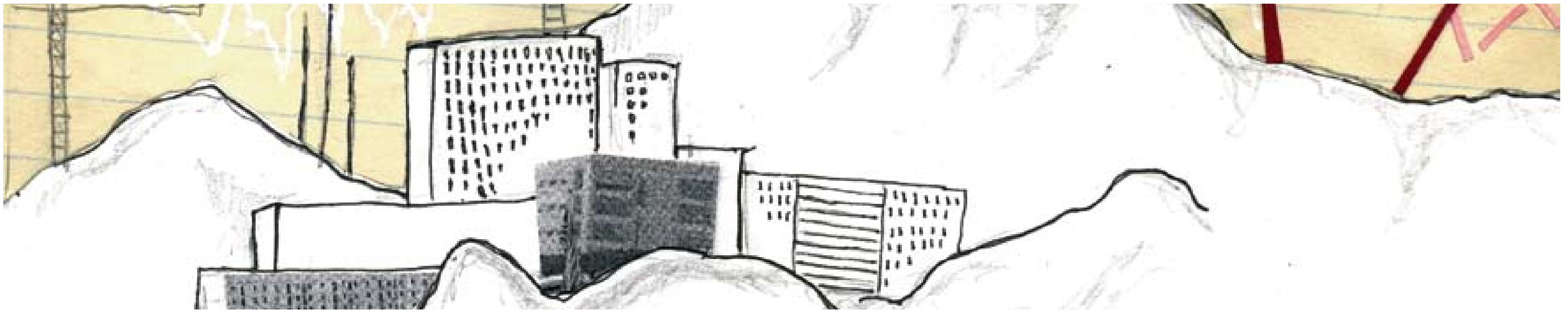
ADAPTING TO CHANGE

The rapid transformation of (West) European countries into modern societies, which took place between the 1830s and World War I, was reflected in rapid increases in suicide mortality in the majority. For Durkheim, this development was both an inspiration to

Table 2. Summary of the Developments in Suicide Mortality in Eastern Europe 1985–1993 According to Suicide Mortality Profiles[a]

Profile	Countries	Years	Total rate[b]	Sex quota[b]	Age quota[b]	Development in Suicide Mortality Between 1985 and 1993
High suicide rate, unequal sex distribution	Belarus, Estonia, Kazakhstan, Latvia, Lithuania, Russia, Slovenia, Ukraine	1985 1989 1993	28.3 25.1 33.4	4.17 3.65 4.57	3.46 3.50 3.03	Large fall in suicide rates 1985–1989, followed by a very large general increase in 1989–1993.
High suicide rate, unequal age distribution	Croatia, East Germany, Hungary	1985 1989 1993	29.7 29.8 26.1	2.76 2.40 2.75	6.02 7.27 5.83	Suicide rates stable 1985–1989, fell somewhat after 1989.
Low suicide rate, unequal sex distribution	Kyrgyzstan, Poland, Romania	1985 1989 1993	13.6 13.6 14.1	4.08 3.72 4.53	3.13 3.26 3.04	Slight increase in suicide rates 1989–1993.
Low suicide rate, unequal age distribution	Bulgaria, Czech Republic, FYR Macedonia, Yugoslavia (Serbia and Montenegro)	1985 1989 1993	16.7 16.3 15.6	2.33 2.44 2.32	8.72 7.18 5.60	Overall trend: falling suicide rates, except for middle-aged people.
Low suicide rate, equal distribution	Albania, Armenia, Azerbaijan, Georgia, Tajikistan, Turkmenistan, Uzbekistan	1985 1989 1993	5.4 4.5 3.6	2.44 2.48 2.50	4.35 2.98 2.36	Overall trend: falling suicide rates, except for the youngest.

[a] Based on: Ilkka H. Mäkinen, "Eastern European Transition and Suicide Mortality", Social Science & Medicine, 2000, vol. 51, pp. 1405–1420.
[b] Mean of the countries. Rate = annual cases per 100,000 inhabitants; sex quota = male suicide rate divided by female suicide rate; age quota = highest age-group suicide rate divided by the lowest one.



and a confirmation of his assumptions about the links between societal regulation/integration and suicide, for these modernizing societies were, in his opinion, characterized by decreasing levels of both. Interestingly, however, suicide mortality levels in the Western world began to stabilize or even decrease some time during the first half of the 20th century – as they did, later, in Greenland – despite a continued modernizing process. While the period between 1945 and 1975 was characterized by unprecedented increases in wealth similar to those experienced during the first phase of modernization, this change was no longer reflected in suicide mortality as it had been a hundred years earlier.[44]

Fortunately, the effects of societal change seem to be of limited duration, at least when it comes to this particular development. The hypothesis has been advanced that the residents of the modernizing world do, eventually, begin to adapt to the experience of continuous transformations. West Europeans have learned to live with the expectation that their lives are characterized by changing and partly unpredictable conditions.[45] It seems that continuous social transformation may be followed, in time, by adaptation, at least in the sense that primary increases in suicide mortality will level off. It is plausible that individuals, as well as societal systems and institutions, learn to anticipate future societal disruptions and develop strategies for handling them.

In Eastern Europe, the period of state socialism during which the Soviet republics and the satellite states were experiencing rapid transformation into modern socialist societies, can be viewed in the light of transformations in 19th century Western Europe of which Durkheim wrote. "East European modernization" was reflected in increases in suicide mortality, as well as in the tendency for suicide mortality to equalize across social classes, the so-called "democratization of suicide".[46] However, any potential adaptation to these transformations was interrupted by a second wave of major transformations, namely the transition from state socialism into market economies.

INDIVIDUALS IN CHANGING SOCIETIES: WAYS OF COPING

After all, the individual is essential to explanations of how a social impulse turns into a social reaction, a step that Durkheim himself, in his methodological works[47], did not acknowledge, but one that has been emphasized by later scholars[48]. One general circumstance that may, to some degree, affect all kinds of changes, is the availability of opportunities for coping with the changed situation. This might be more important than either the nature of the change or the fact of change per se. In their study of regional variations in suicide mortality in Russia 1990–2001, Yelena Andreyeva and her colleagues found that the strongest predictor of suicide mortality levels was the availability of "coping resources" in terms of opportunities to fight a declining living standard by turning to other economic alternatives, legal or illegal. Suicide rates were found to be higher in the provinces where the population lacked such opportunities.[49]

A very important aspect of the changes in East European suicide levels is that they have been far more pronounced among males (and among working-age males in particular). As mentioned above, male suicide mortality is considerably higher than that of females in the majority of countries, China being the only country where the female suicide rate is higher. However, the gap between male and female suicide rates is generally higher in East European countries than in West and North European countries, and this gap grew still further, and increased in relation to Western and Northern Europe, between 1987 and 1992.[50] The changes in Eastern Europe seem to have caused greater increases in male than in female suicide rates. That would indicate that any effect societal changes in Eastern Europe may have had on suicide mortality has been more detrimental to males, which in turn echoes the results of some previous research indicating that men's suicide rates tend to react more than those of women to situations provoked by changing societal circumstances.[51]

In connection with the question posed above, it has been suggested that the gap between male and female suicide mortality rates might have to do with different options for coping with a changed situation. In an attempt to give an explanation of differences between male and female mortality in general in Eastern Europe, Peggy Watson[52] has argued that the importance of the family and the traditional gender roles that derive from the state-socialist era have led men and women to develop different ways of coping with difficulties. Under state socialism, the absence of credible social goals made the management of one's everyday life and family an important personal priority. The traditional gender roles gave women an opportunity for coping by allowing them to focus on just that. Men, on the other hand, did not have this option – their position as breadwinners was more problematic, as it was difficult to develop meaningful roles in the work situation. In connection with the transition period, which was marked by rising unemployment, reduced income, and uncertainty, men's ways of coping became even more limited and fraught with difficulties.

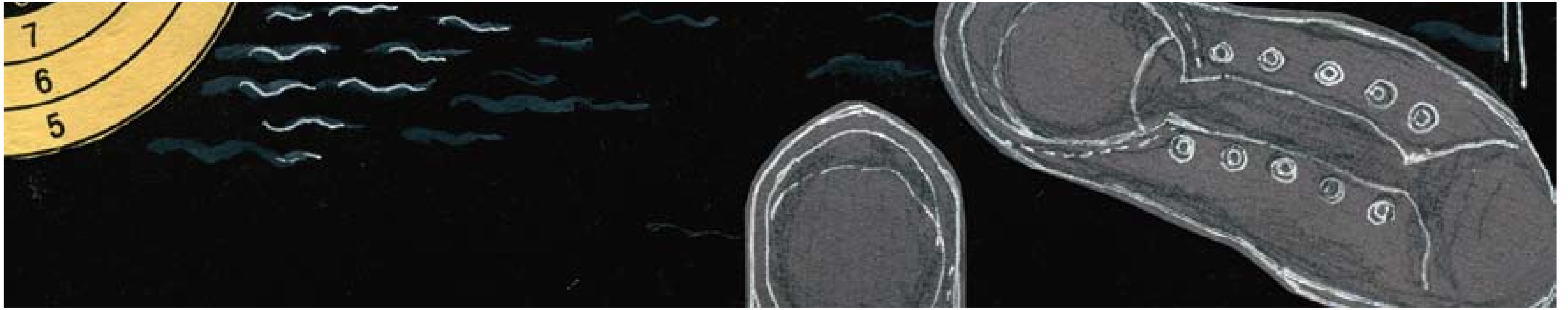
As regards the general male-female difference in suicide, Anne Maria Möller-Leimkuehler[53] maintains that part of the explanation lies in masculine stereotypes and the coping behaviors they permit. Masculine stereotypes do not allow men to talk about their feelings or seek help, even when in need of it, while female gender roles allow women to do so. This probably also helps them to cope better with difficulties Moreover, stereotypical male gender roles do not allow men to lose control or relinquish mastery. Under stressful circumstances, suicide may be seen as a way of taking control of and changing one's situation.

Considering variations in suicide mortality, it seems curious that the largest increases after 1990 were observed in those countries that already had the highest suicide levels. If increases in suicide mortality are related to coping opportunities, as has been suggested above, then perhaps one could view suicide as a way of coping in times when alternative means of coping are scarce. In this manner, it might also be possible to see the simultaneous increase in alcohol consumption as *parallel*, rather than *prior*, to suicide; alcohol consumption would thus also, basically, be an alternative way of coping. If one takes this point of view, one may ask whether the likelihood of choosing suicide as a way of coping in a specific situation might depend on the degree to which suicide (or alcohol consumption for that matter) is already present in that particular culture. In this sense, it might be expected that the greatest variations in suicide mortality would be seen in countries where the suicide mortality level is already high.

CONCLUSIONS

The fact that sharp increases in suicide mortality seem to have been a rather common element in many changing societies clearly demonstrates the accuracy of Durkheim's description of suicide as a societal, rather than individual, phenomenon. However, societal changes are complex phenomena, and determining the potential trigger for increases in suicide levels is, it seems, very complicated. In the end, the result will most probably reflect the investigator's choice of perspective. More interesting is perhaps the fact that societal change does not always appear to be accompanied by increases in suicide mortality, and when it is, it seems to be so for only a limited period of time immediately after the initial change. Above, it was suggested that the effect of societal change on suicide levels ultimately depends on the cultural context where it occurs. One might further hypothesize that suicide, as

Where many kill themselves, the risk that more will do it is great. That is, a contagion.



a way of coping with societal change or, alternatively, as a result of such change, is a much more readily available (if not mandatory) option in some cultures than in others. If other ways of coping are available, there may be less of a tendency to choose the option of suicide. This is perhaps the case for women in Eastern Europe. The development of means of coping could be an ingredient in the adaptation to societal change, which is indicated by the falling or stabilizing suicide rates in Western Europe in the first half of the 20th century. ≈

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No small matter. This is what a reference section should look like in Baltic Worlds.